ECHN CorpCare
Occupational Health

Healthcare Worker Supplementary History

Name: _____ Date of Birth: _____
Company: _____ Job: _____

Have either of your parents and/or siblings had:

○ Hay Fever ○ Asthma ○ Eczema

Within the past month, have you had: (Check all that apply)

○ Fever ○ Weight loss ○ Skin Rash ○ Persistent Cough
○ Night Sweats ○ Persistent Fatigue ○ Diarrhea ○ Draining Wound
○ Eye Infection or Pink Eye

Do you have a history of :

○ Hayfever ○ Eczema ○ Contact Dermatitis ○ Persistent Cough
○ Asthma ○ Anaphylaxis

Do you have any allergies? ○ Yes ○ No
If YES what are they? _____

Specifically, do you have an allergy to any of the following? (Check all that apply)

○ Banana ○ Fig ○ Melon ○ Potato ○ Avocado
○ Nectarine ○ Poinsettia ○ Chestnuts ○ Papaya ○ Plum
○ Peaches ○ Milk ○ Kiwi ○ Cherry ○ Tomato
○ Yeast ○ Thiomersal

Have you ever had an allergic reaction to latex products? ○ Yes ○ No
If YES what products? _____

Specifically, have you had an allergic reaction to any of the following? (Check all that apply)

○ Balloons ○ Dental Masks ○ Baby bottle nipples ○ Carpet Backing ○ Erasers
○ Rubber gloves ○ Cuffs, Elastic Waistband ○ Weather Stripping ○ Hot Water Bottles ○ Band-Aids
○ Adhesive Tape ○ Face Masks ○ Garden Hose ○ Rubber Cement ○ Ostomy Bags
○ Foam Rubber ○ Condoms ○ Diaphragms ○ Ace Bandages

After handling latex or rubber products, have you experienced any of the following?
(Check all that apply)

○ Skin Redness ○ Swelling ○ Dermatitis ○ Runny Nose ○ Hives
○ Difficulty Breathing ○ Itching ○ Watery Eyes

Have you had an allergic reaction during a medical/dental procedure? ○ Yes ○ No

Has a physician ever told you that you have a rubber or latex allergy? ○ Yes ○ No

Physician Comments: _____
_____
_____

Please email the completed form to corpcare@echn.org prior to your scheduled appointment.